


March 2010

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Recommended Citation

Davis, Katherine (2010) "Application of a Leadership Approach to Address Suicide among Gay, Lesbian and Bisexual Youth," *Florida Public Health Review*: Vol. 7 , Article 2.

Available at: <https://digitalcommons.unf.edu/fphr/vol7/iss1/2>

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Application of a Leadership Approach to Address Suicide among Gay, Lesbian and Bisexual Youth

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ABSTRACT

Suicide, especially among youth, is a significant public health issue, ranking as the third leading cause of death among youth and young adults between the ages of 10 and 24. Suicide attempts and successful suicides are more frequent occurrences in the gay, lesbian, and bisexual (GLB) population. Despite this heightened risk, sexual orientation is omitted from important documents that detail suicide risk factors. Moreover, few schools have programs that address the unique needs of GLB youth that could create a more receptive or tolerant, and less threatening environment for them. In this paper, Kotter's eight-stage framework for leadership is explored for its possible contribution to advancing dialogue and action about this public health and school health issue.

Florida Public Health Review, 2010; 7, 4-8.

Introduction

Suicide claims over 30,000 lives annually in the United States. Suicide is a major public health issue and has been a health risk behavioral issue among youth because of its ranking as a leading cause of death in that population. Suicide prevention is a key goal of health education and suicide risk factors have been studied, identified and published for many years. Despite continuous research suggesting that sexual orientation is a possible risk factor for youth suicide there is currently no effort to address the issue by the schools. The World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) collect statistics and develop prevention strategies for suicide but neither discusses or focuses on the higher incidence of suicide in the gay, lesbian and bisexual (GLB) population. The leadership model developed by Kotter (1986; 1996) has the potential for application by health educators and other personnel in school settings to address the issues surrounding GLB youth, including increased risk for suicide.

Background

According to the CDC (2008), suicide is the third leading overall cause of death for individuals between the ages of 10 and 24. Suicide is responsible for ending the lives of roughly 4500 young people each year. Risk factors for youth suicide as listed by the CDC (2008) include a family history of suicide, a history of depression or mental illness, alcohol or drug abuse, stressful life event or loss, easy access to lethal methods, exposure to the suicidal behavior of

others and incarceration. The CDC (2008) also notes that certain groups should be considered at special risk for suicide: boys, Native Americans, Alaska Natives, and Hispanics. In 1989, the Department of Health and Human Services published the *Report of the Secretary's Task Force on Youth Suicide* which stated that gay and lesbian youth were two to three times more likely to attempt suicide than their heterosexual peers, and up to 30% of all completed suicides could potentially be attributed to the gay and lesbian youth population (Remafedi, 1999). However, in a current CDC (2008) text there is no mention of sexual orientation as a risk factor for suicide in that age group. This complete disregard of an identified risk factor for youth suicide transcends into health education within schools where the special needs of GLB youth are, more often than not, ignored. The failure to incorporate GLB content in schools may possibly increase their risk of suicide. Without the introduction of same-sex behaviors, safer sex practices and positive role models to which they can relate, GLB youth feel isolated and ashamed. This omission and subsequent lack of understanding is of particular concern because Durkheim's sociological theory of suicide suggests that one of the major factors that contributes to individuals ending their lives is a lack of integration into the dominant culture (Morrison & L'Heureux, 2001).

Significance of the Problem

There is no way to determine sexual orientation after death; therefore, statistics on GLB suicide are based upon the higher incidence of suicide attempts

Florida Public Health Review, 2010; 7:4-8.
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in the population and the seriousness of these attempts. Multiple suicide attempts are seen in the GLB population and those continuous attempts are considered to be a risk factor for completion of suicide. Approximately 12,000 youth took part in the National Longitudinal Study of Adolescent Health and from that sample 7% self-reported same sex attractions or relationships. Several studies performed over the last 25 years have reached the same conclusion time and time again. Using multiple methods and settings, researchers have found that those considered members of the sexual orientation minority report more suicidal ideations, attempts and plans than their sexual majority peers (Russell & Joyner, 2001). With the removal of age and family background, males and females who reported same sex attraction were more likely than their heterosexual peers to report suicidal thoughts. Over the last ten years the age at which one identifies as gay, lesbian, or bisexual has changed significantly. Males now identify same sex attraction at the age of 10 and females do so around the age of 11 (Tellingator & Woyewodizic, 2009). In a sample of 137 males aged 14-21 who identified as gay or bisexual, over half reported a suicide attempt on more than one occasion (Remafedi, Farrow, & Deisher, 1991). In 2008, the Suicide Prevention Resource Center released a publication titled *Suicide Risk and Prevention for Lesbian, Gay, Bisexual, and Transgender Youth*. The Resource Center reported that prevention programs can be effective at reducing risk the risk factors associated with suicide. However, the publication also stated that few, if any, programs are targeted at GLB youth. This deficit occurs despite the fact that 28.1% of males who were in grades 7-12 and also identified as gay or bisexual had at least one suicide attempt. Only 4.2% of their heterosexual counterparts attempted suicide. The statistics for females with at least one suicide attempt in the same age group was 20.5% among lesbian or bisexual females compared to only 14.5% of heterosexual females. About 58% of homosexuals who attempted suicide had intentions to die whereas only 33% of heterosexuals had serious hopes of death (Suicide Prevention Resource Center, 2008). The Youth Risk Behavior Surveillance System (YRBSS) used by the CDC to monitor priority health risk behaviors of youth in grades 9 through 12 does not address the increased suicide risk of the GLB population. However, a minority of states have elected to collect data and compile statistics on youth who engage in same sex activities. In 2001, both Vermont and Massachusetts used the YRBSS as a platform to report on same-sex activity among their youth. Information was gathered by asking questions that elicited answers in regards to engagement in same-

sex experiences. Vermont youth exposure rates to same-sex experiences were reported at 3% overall and Massachusetts at 5% overall. Using 2002 statistics from the U.S. Department of Education, researchers have been able to make a conservative estimate of the total number of GLB youth receiving education within the United States. There were 13.8 million students in grades 9-12 in 2002; using Vermont's statistics as a gauge would imply that there are approximately 414,000 GLB youth in the U.S. school system. Applying Massachusetts results would estimate that total of GLB students to be closer to 689,000 (Cianciotto & Cahill, 2003). In addition, in 1995 the Massachusetts Department of Education found that students who self-identified as GLB or admitted same-sex experiences were notably more likely to attempt suicide, experience threats, and abuse drugs/alcohol compared to their heterosexual counterparts. Enumeration further illustrated that GLB youth were four times more likely to attempt suicide in contrast to non-GLB youth (Massachusetts Department of Education, 1995). The significance found when Vermont and Massachusetts numbers are applied is evidence that a vast proportion of the population is being excluded by the health curriculum in schools. Moreover, current GLB suicide data are consistent with those of the 1989 report of the U.S. Department of Health and Human Services.

Factors Related to or Affecting the Problem

GLB youth face a number of identified risk factors that make them more susceptible to suicide attempts: coming out at an earlier age, sexual abuse, nondisclosure of sexual orientation, intrapersonal conflict in terms of their sexual orientation, and gender non-conformity. When teachers and peers are tolerant of homophobic attitudes in school settings, there is the potential to increase the risk of suicide in GLB youth (Morrison & L'Heureux, 2001). The 2007 School Climate Survey conducted by the Gay, Lesbian, and Straight Education Network (GLSEN) found that among the GLB youth surveyed, more than half reported they felt unsafe at school based because of their sexual orientation. Accounts of victimization involving GLB youth in schools include both verbal harassment and physical attacks. Over 80% surveyed reported being verbally harassed, and within the year prior to reporting, over half had been physically harassed due to their sexual orientation. In 2003, only 13 states and the District of Columbia had a law or regulation specifically created to address bias and harassment based on sexual orientation in effect (Cianciotto & Cahill, 2003). Using a suicide risk assessment, researchers determined that if a GLB youth attends a school with policies regarding non-discrimination based on

sexual orientation in place and diversity training is provided for staff, teachers and peers on GLB issues then the student may be less likely to encounter harassment and homophobia in school. In turn, they may be less likely to engage in suicidal or other self-injury behaviors (Morrison & L'Heurux, 2001). Abstinence-only programs exclude GLB youth, fail to teach them safer sex practices, provide them with no positive role models, and emotionally isolate them from their peers. Emotional isolation is correlated with an increased rate of suicide in GLB youth. The major youth suicide risks as listed by the CDC are also seen at higher rates in GLB youth (Silenzio et al., 2007). Depression and substance abuse are known predecessors to suicidal behaviors. Research reports findings of higher rates of both depression and substance abuse among GLB youth. The increased incidence of those behaviors in GLB youth is thought to be related to the concealing of their sexual orientation from others (Russell & Joyner, 2001). About 87% of students surveyed by GLSEN reported they had not been taught about a GLB or transgendered individual in any of their classes. Less than half of students stated they could find information on GLB individuals in their school library and only about 14% said GLB information could be found within their textbooks. Homophobic remarks were deemed as heard frequently by almost 75% of students surveyed by GLSEN. About 60 % of GLB youth who faced harassment in school did not report it to anyone because they felt no action would be taken. Feeling unsafe at school is a major issue for GLB youth compared to their non-GLB peers. Almost one in three (32%) lesbian students reported missing at least one day of school for safety concerns, whereas only 4.5% in a national sample of all students reported missing a school day for the same reason (Kosciw, Diaz, & Greytak, 2008). GLB students are at a disadvantage compared to other students in regards to the support services available to them within schools. A study of 120 gay and lesbian students in 1993 found that just 25% felt as though they could communicate with school counselors regarding their sexual orientation. Not one student in the study stated that school staff members were a major source of support for them. Most teachers and staff are reluctant to discuss issues related to sexual orientation, and heterosexual teachers could be hesitant because of inadequate knowledge and concerns they may have about addressing sexual issues in general with students. Factors such as fear of parents' reactions, their job security, and their own religious or moral views also play a role in this reluctance (Cianciotto & Cahill, 2003).

Implications for Leadership

School health educators have the opportunity to apply a leadership model such as the one developed by Kotter (1986; 1996) to address the lack of health education and support services available to GLB youth. The probability of decreasing suicide risk in the GLB school population will exist. Kotter (1986) defined leadership as "motivating and inspiring -- energizing people to overcome major political, bureaucratic, and resource barriers to change by satisfying basic, but often unfulfilled, human needs." Leadership is outlined in eight steps by Kotter (1986; 1996) with the first being to establish a sense of urgency which is the time to identify and discuss a potential crisis. The second step is to create a guiding coalition which is also known as putting together a group with enough power to lead the change. Next is to develop a vision and strategy where the vision will be used to direct the change and the strategy to achieve the change. From there the goal is to communicate the change vision. Every possible means to facilitate change should be used while the guiding coalition acts as role models to others. Empowering broad-based action is the time to remove any obstacles that stand in the way of change and encourage risk taking. Step six is to generate short-term wins which includes planning for observable wins and then acknowledging those who made the wins achievable. Finally, consolidating gains and producing more change will be followed by anchoring the new approaches in the culture. Consolidating gains and producing more change means keeping what works, getting rid of what does not, and reinventing the process by introducing new ways of change. To anchor the change in culture leadership becomes vital (Kotter, 1996). Suicide among GLB youth is a critical issue and school health educators can create the sense of urgency that should surround the topic. As more and more states opt out of abstinence-only funding it is imperative to incorporate GLB issues into health education courses. A collaborative survey performed by National Public Radio, the Kaiser Family Foundation and Harvard University's Kennedy School of Government (2004) found that the 73% of the American public agreed that homosexuality and sexual orientation are appropriate topics for students in both middle and high school. A guiding coalition or team should consist of school health educators, teachers, school administrators and school policy makers who together, can develop a vision to address the needs of GLB youth. The vision should consist not only of incorporating sexual orientation and GLB issues into health education courses, but also providing diversity training for all faculty and students. The development of non-discrimination policies also should occur

where such policies are not already in place. Communicating the vision should be addressed at all levels from students, educators, parents, administrators, and policy makers. Short-term wins could be measured by a decrease in absenteeism among GLB students, adherence of others to non-discrimination policies and overall feelings of safety and security. Producing more change should occur at the policy level which would force the anchoring of the new approaches into school culture. A report by the Suicide Prevention Resource Center (2008) provided suggestions as to how settings such as schools could increase protective factors and decrease risk factors for suicide among GLB youth. These included “promote organizations that support GLB youth such as Gay-Straight Alliances, develop peer-based support programs and make accurate information about GLB issues and resources easily available. Use a GLB cultural competence model that enables individuals and agencies to work effectively with GLB youth cultures. Institute, enforce, and keep up to date non-discrimination and non-harassment policies for all youth. Assume that clients or students could be any sexual orientation or gender identity and respond accordingly. Address explicitly the needs of GLB youth in school-based programs and policies to prevent violence and bullying. Assess and ensure that youth services and providers are inclusive, responsive to, and affirming of the needs of GLB youth, and refer youth to these services and providers” (p.7). According to the 2007 National School Climate Survey if gay, lesbian or bisexual students felt as though the school had GLB supportive educators they were less likely to miss school, more likely to have a higher grade point average (GPA), and most importantly, feel a greater sense of belonging in their school environment (Kosciw, Diaz, & Greytak, 2008). Providing GLB students with a safe and positive atmosphere in schools could eradicate one of the major reasons GLB youth commit suicide, the lack of integration into dominant culture. A tolerant and accepting school setting with adequate educational and support services could likely decrease the risk of suicide among GLB youth. It also could favorably influence overall health of GLB students by increasing safer sex practices. School health educators are on the forefront for achieving such an environment. However, they must first be educated on the needs of the GLB youth they will serve, be made aware of the increased risk of suicide among GLB youth, and be given the necessary tools and opportunities to address the issue.

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